STATE OF CALIFORNIA-DEPARTMENT OF FINANCE

### PAYEE DATA RECORD

Required when receiving payment from the State of California in lieu of IRS W-9) 204 (Rev. 6-2003)

1	INSTRUCTIONS: Complete all information on this form. Sign, date, and return to the State agency (department/office) the bottom of this page. Prompt return of this fully completed form will prevent delays when processing payments. Information will be used by State agencies to prepare Information Returns (1099). See reverse side for more information a Statement.  NOTE: Governmental entities, federal, State, and local (including school districts), are not required to submit this form.	rmation provided in
2	PAYEE'S LEGAL BUSINESS NAME (Type or Print)  THE PROPRIETOR - ENTER NAME AS SHOWN ON SSN (Last, First, M.I.)  E-MAIL ADDRESS	
	the primary source	emsn.com
	MAILING ADDRESS  11367 Trade Center Dr #110 Same	
****	Rancho Cordova, CA 957H2 Same	
3	ENTER FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN): 01-08041114	NOTE:
PAYEE	PARTNERSHIP CORPORATION:  MEDICAL (e.g., dentistry, psychotherapy, chiropractic, etc.)	Payment will not be processed without an
ENTITY TYPE	ESTATE OR TRUST  LEGAL (e.g., attorney services)  EXEMPT (nonprofit)  ALL OTHERS	accompanying taxpayer I.D. number.
CHECK ONE BOX ONLY	INDIVIDUAL OR SOLE PROPRIETOR ENTER SOCIAL SECURITY NUMBER:	
4	(SSN required by authority of California Revenue and Tax Code Section 18646)  California resident - Qualified to do business in California or maintains a permanent place of business	o in California
	California nonresident (see reverse side) - Payments to nonresidents for services may be subject to S	
PAYEE RESIDENCY STATUS	withholding. ☐ No services performed in California. ☐ Copy of Franchise Tax Board waiver of State withholding attached.	
5	I hereby certify under penalty of perjury that the information provided on this document is true Should my residency status change, I will promptly notify the State agency below.	and correct.
	AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print)  BONNIE CEVELESKI  Preside	ent
	BOMUL CURRENT 5-01-06 916 858-	2099
	Please return completed form to:	
6	Department/Office: Depart of General Services	_
	Unit/Section: <u>Procurement Division</u> Mailing Address: 707 3rd St.	-
	11/0.1 600.000	_
	011 705 11400 1011 505-1110	-
;	Telephone: <u>(116 3 /5 - 777 /8 Fax: (914 3 /5 4613</u> ) E-mail Address: Mallie of Stone & Jas. Ca. 90V	-
	L-man Address. Milling of the Court of Court	-

**EXHIBIT 8.7** 

ST CALIFORNIA-DEPARTMENT OF FINANCE

Ρ	F	ΞE	DA.	TΑ	RE	CO	RD	

(Required when receiving payment from the State of California in lieu of IRS W-9) STD. 204 (Rev. 6-2003)

1	INSTRUCTIONS: Complete all information on this form. Sign, the bottom of this page. Prompt return of this fully completed for this form will be used by State agencies to prepare Information R Statement.  NOTE: Governmental entities, federal, State, and local (including the complete of	orm will prevent de eturns (1099). Se	lays when processing payments. Info e reverse side for more information a	rmation provided in
	PAYEE'S LEGAL BUSINESS NAME (Type or Print)	echnologies,		
2				
	SOLE PROPRIETOR - ENTER NAME AS SHOWN ON SSN (La	st, First, M.I.)	eric@cufis.com	1
,	MAILING ADDRESS	BUSINESS ADD		
	4231 Pacific Street, Suite 3	1	fic Street, Suite 3	
	CITY, STATE, ZIP CODE Rocklin, CA 95677	CITY, STATE, ZI Rocklin, C		
	NOCKIIII, CA 93077	Trockini, c		
3	ENTER FEDERAL EMPLOYER IDENTIFICATION NUMBER (	(FEIN): 2 0	-2124438	NOTE:
	PARTNERSHIP CORPORATION:			Payment will not be processed
PAYEE ENTITY		(e.g., dentistry, psych g., attorney services)	otherapy, chiropractic, etc.)	without an accompanying
TYPE	EXEMPT (	nonprofit)	. ,	taxpayer I.D. number.
CHECK	□ ALL OTHE	RS		
ONE BOX	INDIVIDUAL OR SOLE PROPRIETOR	-    -		*
ONLY	ENTER SOCIAL SECURITY NUMBER:  (SSN required by a	authority of California	Revenue and Tax Code Section 18646)	
4	California resident - Qualified to do business in Cal	lifornia or maintai	ins a permanent place of busines	s in California.
	California nonresident (see reverse side) - Paymen			
PAYEE	withholding.			
RESIDENCY STATUS	<ul><li>No services performed in California.</li><li>Copy of Franchise Tax Board waiver of</li></ul>	State withholding	g attached.	
5	I hereby certify under penalty of perjury that the	information pro	vided on this document is true	and correct.
	Should my residency status change		notity the State agency below.	
	AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or P	rint)	TITLE President	
	Eric Hoffman	DATE	TELEPHONE	
	SIGNATURE	05/31/20	016 652 4	118
	Please return complete form to:	03/31/20		i
6	Department Office:			
	Unit/Section:			
	Mailing Address:			
	City/State/Zip:			
	Telephone: ()			_
				-
	E-mail Address:			

EXHIBIT 8.7

STATE OF CALIFORNIA-DEPARTMENT OF FINANCE

#### PAYEE DATA RECORD

(Required when receiving payment from the State of California in lieu of IRS W-9)

	INSTRUCTIONS: Complete all information on this form. Sign, date, and return to the State agency (department/office) the bottom of this page. Prompt return of this fully completed form will prevent delays when processing payments. Info	address shown at
	this form will be used by State agencies to prepare Information Returns (1099). See reverse side for more information a	nd Privacy
	Statement.  NOTE: Governmental entities, federal, State, and local (including school districts), are not required to submit this form.	
-1	PAYEE'S I EGAL BUSINESS NAME (Type or Print)	
<u> </u>	DATICA, INC db2 The Very Last Word Sole PROPRIETOR - ENTER NAME AS SHOWN ON SSN (Last, First, M.) E-MAIL ADDRESS	
2	SOLE PROPRIETOR - ENTER NAME AS SHOWN ON SSN (Last, First, M.) E-MAIL ADDRESS	
	MAILING ADDRESS  BUSINESS ADDRESS	
	50 E. HAMILTON AVE., Ste 280 Same	
	CITY, STATE, ZIP CODE	
	50 E. HAMILTON AVE., Ste 280 Semb CITY, STATE, ZIP CODE CAMPBELL, CA 95008 Semb	
	ENTER FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN): $ 7 7 - 0 4 2 8 5 6 5 $	NOTE
3		NOTE: Payment will not
	PARTNERSHIP CORPORATION:	be processed without ап
PAYEE ENTITY	☐ MEDICAL (e.g., dentistry, psychotherapy, chiropractic, etc.)         ☐ ESTATE OR TRUST       ☐ LEGAL (e.g., attorney services)	accompanying
TYPE	EXEMPT (nonprofit)	taxpayer I.D. number.
CHECK	ALL OTHERS	
CHECK ONE BOX	INDIVIDUAL OR SOLE PROPRIETOR         _	
ONLY	ENTER SOCIAL SECURITY NUMBER:	
	(SSN required by authority of California Revenue and Tax Code Section 18646)	
'   4	California resident - Qualified to do business in California or maintains a permanent place of business	s in California.
/ <b>L</b>	California nonresident (see reverse side) - Payments to nonresidents for services may be subject to S	tate income tax
PAYEE	withholding.	
RESIDENCY STATUS	<ul><li>No services performed in California.</li><li>Copy of Franchise Tax Board waiver of State withholding attached.</li></ul>	
OTA TOO		
[ F	I hereby certify under penalty of perjury that the information provided on this document is true	and correct.
5	Should my residency status change, I will promptly notify the State agency below.	
	AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print)  TITLE	
	ROBERT D. FARRELL President	
	SIGNATURE / DATE TELEPHONE	
	Tune 1, 2006 408, 341-8	8809
	Please return completed form to:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
6	Department/Office:	
	Department/Office:	-
	Unit/Section:	_
	Mailing Address:	_
	City/State/Zip:	,
		- ·
	Telephone: () Fax: ()	_
	E-mail Address:	-

EXHIBIT 8.7

STATE OF CALIFORNIA-DEPARTMENT OF FINANCE

#### PAYEE DATA RECORD

'Required when receiving payment from the State of California in lieu of IRS W-9) 204 (Rev. 6-2003)

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	NOTE: Governmental entities, federal, State, and local (including school districts), are not required to submit this form.	
	PAYEE'S LEGAL BUSINESS NAME (Type or Print)	
2	SOLE PROPRIETOR - ENTER NAME AS SHOWN ON SSN (Last, First, M.I.) E-MAIL ADDRESS	
		600000
	MAILING ADDRESS BUSINESS ADDRESS	Follaper, V
	MAILING ADDRESS	9
	12436 SANTA MONICA BAME	
	CITY, STATE, ZIP CODE CITY, STATE, ZIP CODE	
	Los Angeles, CA 90025 Same	·
3	ENTER FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN): 95-4305358	NOTE: Payment will not
	PARTNERSHIP CORPORATION:	be processed
PAYEE	MEDICAL (e.g., dentistry, psychotherapy, chiropractic, etc.)	without an accompanying
ENTITY	ESTATE OR TRUST  LEGAL (e.g., attomey services)  EXEMPT (nonprofit)	taxpayer I.D.
TYPE	ALL OTHERS	number.
CHECK ONE BOX	INDIVIDUAL OR SOLE PROPRIETOR	
ONLY	ENTER SOCIAL SECURITY NUMBER:  (SSN required by authority of California Revenue and Tax Code Section 18646)	
' 4	California resident - Qualified to do business in California or maintains a permanent place of busines	s in California.
_/	California nonresident (see reverse side) - Payments to nonresidents for services may be subject to S	State income tax
PAYEE	withholding.	
RESIDENCY	□ No services performed in California.	
STATUS	☐ Copy of Franchise Tax Board waiver of State withholding attached.	
5	I hereby certify under penalty of perjury that the information provided on this document is true Should my residency status change, I will promptly notify the State agency below.	and correct.
	AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print) TITLE	
	SIGNATURE  SIGNATURE  SIGNATURE  DATE  DATE  TELEPHONE  310) 450-	. Sales Man
	SIGNATURE DATE TELEPHONE	0
	1 h/ 6/1/01 2/0 c/co-	2708
	Blue of the completed for to	0 ,00
	Please eturn completed form to:	
6	Department/Office:	_
	Unit/Section:	_
	Mailing Address:	_ ,
	City/State/Zip:	_
	Telephone: () Fax: ()	_
	E-mail Address:	_

# RFP DGS-55206

STATE OF CALIFORNA-DEPARTMENT OF FINANCE

PAYEE DATA RECORD

Section 8

EXHIBIT 8.7

(Required when receiving payment from the State of California in lieu of IRS W-8) STD. 204 (Rev. 6-2003)

1	INSTRUCTIONS: Complete all Information on this form. Sign, date, and return to the State agency (department/office the bottom of this page. Prompt cutum of this fully completed form will propert delays unless agency.	a) addmon phase at			
'	the bottom of this page. Prompt return of this fully completed form will prevent delays when processing payments. Information provided in Statement.  Statement.				
	Statement.	and Privacy			
***************************************	NOTE: Governmental entities, federal, State, and local (including school districts), are not required to submit this form.  PAYEE'S LEGAL BUSINESS NAME (Type or Print)				
	CONTRACTOR TARGET (Type or Print)				
2	SOLE PROPRIETOR - ENTER NAME AS SHOWN ON SSN (Last, First, M.I.) E-MAIL ADDRESS				
	MAILING ADDRESS Cliff & Walde	cus, on			
	CI DO LOS ADDRESS				
	and and				
	CITY, STATE, ZIP CODE				
	Jan alasa of till som.	• .			
3	ENTER FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN): 99-129517 St 60				
		NOTE:			
PAYEE		Payment will not be processed			
ENTITY	ESTATE OR TRUST  MEDICAL (e.g., dentistry, psychotherapy, chiropractic, etc.)  LEGAL (e.g., attorney services)	without an accompanying			
TYPE	LI EXEMPT (nonprofit)	taxpayer I.D.			
CHECK	ALL OTHERS	number.			
ONE BOX	INDIVIDUAL OR SOLE PROPRIETOR				
ONLY	ENTER SOCIAL SECURITY NUMBER:				
	(SSN required by authority of Galifornia Revenue and Tax Code Section 18548)				
4	California resident - Qualified to do business in California or maintains a permanent place of business	:- O-10			
	California prorresident (see voyerne side). Deserve	in California.			
PAYEE	California nonresident (see reverse side) - Payments to nonresidents for services may be subject to S withholding.	tate income tax			
RESIDENCY	No services performed in California.				
SIAIUS	Copy of Franchise Tax Board waiver of State withholding attached.				
<u></u>					
5	I hereby certify under penalty of perjury that the information provided on this document is true a	nd correct.			
<b>!</b>	state agency below.				
Ì	AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type of Print),				
	- Citterd Walneck Milder	•			
	SIGNATURE DATE DATE TELEPHONE				
	S102106 1415, 9x1,3	34)			
	Please return completed form to:	20			
6	Department/Office;				
L					
	Unit/Section:				
	Mailing Address:	ĺ			
"	City/State/Zip:				
	Telephone: ()Fax: ()				
	E-mail Address:				

STATE OF CALIFORNIA-DEPARTMENT OF FINANCE

### **PAYEE DATA RECORD**

(Required when receiving payment from the State of California in lieu of IRS W-9) STD. 204 (Rev. 6-2003)

1	INSTRUCTIONS: Complete all information on this form. Sign, date, and return to the State agency (department/office) address shown at the bottom of this page. Prompt return of this fully completed form will prevent delays when processing payments. Information provided in this form will be used by State agencies to prepare Information Returns (1099). See reverse side for more information and Privacy Statement.  NOTE: Governmental entities, federal, State, and local (including school districts), are not required to submit this form.				
	PAYEE'S LEGAL BUSINESS NAME (Type or Print)				
2	THE MARTINI GROUP, INC.				
-	SOLE PROPRIETOR - ENTER NAME AS SHOWN ON SSN (L	.ast, First, M.I.)	E-MAIL ADDRESS		
			GLATONA@MARTINIGLO	BAL.COM	
	MAILING ADDRESS	BUSINESS ADD			
	245 FISCHER AVE., BLD. C-2	245 FISCHER	AVE., BLD. C-2		
	CITY, STATE, ZIP CODE	CITY, STATE, Z			
	COSTA MESA, CA 92626	COSTA MESA	A, CA 92626		
PAYEE ENTITY TYPE		e.g., dentistry, psyche.g., attorney services)	- 0 0 6 9 0 5 6	NOTE: Payment will not be processed without an accompanying taxpayer I.D. number.	
CHECK ONE BOX ONLY	INDIVIDUAL OR SOLE PROPRIETOR ENTER SOCIAL SECURITY NUMBER: (SSN required by	authority of California	Revenue and Tax Code Section 18646)		
PAYEE RESIDENCY STATUS	California resident - Qualified to do business in California nonresident (see reverse side) - Paymer withholding.  No services performed in California. Copy of Franchise Tax Board waiver of	nts to nonresident	ts for services may be subject to		
5	I hereby certify under penalty of perjury that the Should my residency status change	information pro e, I will promptly	vided on this document is true notify the State agency below.	and correct.	
	AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or F	Print)	TITLE		
	GLEN LATONA		PRESIDENT		
•	SIGNATURE	DATE	TELEPHONE		
	Oten from	09/27/2006	(714)210-2501		
	Please return completed form to:				
6	Department/Office:			<u>.</u>	
	Unit/Section:				
	Mailing Address:			_	
	City/State/Zip:			_	
	Telephone: ()	Fax: (	_)		
	E-mail Address:	***************************************			

EXHIBIT 8.7

STATE OF CALIFORNIA-DEPARTMENT OF FINANCE

### PAYEE DATA RECORD

Required when receiving payment from the State of California in lieu of IRS W-9) STD. 204 (Rev. 6-2003)

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	NOTE: Governmental entities, federal, State, and local (including school districts), are not required to submit this form.
	PAYEE'S LEGAL BUSINESS NAME (Type or Print)
2	DNBE lech Inc.
	SOLE PROPRIETOR - ENTER NAME AS SHOWN ON SSN (Last, First, M.I.)  E-MAIL ADDRESS
	Eckert, Mark, mark@dvbetech.com  MAILING ADDRESS  BUSINESS ADDRESS
	Ta C
	CITY, STATE, ZIP CODE CITY, STATE, ZIP CODE
	Fair Oaks, CA 95628 same
	ENTER FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN):   68 - 0459531   NOTE:
3	Payment will not
PAYEE	PARTNERSHIP CORPORATION:  □ MEDICAL (e.g., dentistry, psychotherapy, chiropractic, etc.)  be processed without an
ENTITY	ESTATE OR TRUST LEGAL (e.g., attorney services)
TYPE	EXEMPT (nonprofit)  ALL OTHERS  Laxpayer 1.D.  number.
CHECK	7 7.63 5 112.10
ONE BOX ONLY	INDIVIDUAL OR SOLE PROPRIETOR ENTER SOCIAL SECURITY NUMBER:
ONL	(SSN required by authority of California Revenue and Tax Code Section 18646)
4	California resident - Qualified to do business in California or maintains a permanent place of business in California.
	- Same resident de same le de same la competition de maintaine à portugion place of basiness in Cambrida.
DAVEE	California nonresident (see reverse side) - Payments to nonresidents for services may be subject to State income tax withholding.
PAYEE RESIDENCY	☐ No services performed in California.
STATUS	☐ Copy of Franchise Tax Board waiver of State withholding attached.
<u> </u>	
5	I hereby certify under penalty of perjury that the information provided on this document is true and correct. Should my residency status change, I will promptly notify the State agency below.
	AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print)  TITLE
	Mark Eckert  SIGNATURE TELEPHONE
	Please return completed form to: May 5, 2006 (916, 960 - 0116 ext. 11)
6	
	Department/Office:
	Unit/Section:
	Mailing Address:
	City/State/Zip:
	Telephone: () Fax: ()
	E-mail Address:

EXHIBIT 8.7

STATE OF CALIFORNIA-DEPARTMENT OF FINANCE

### PAYEE DATA RECORD

'Required when receiving payment from the State of California in lieu of IRS W-9) TD. 204 (Rev. 6-2003)

1	INSTRUCTIONS: Complete all information on this form. Sign, the bottom of this page. Prompt return of this fully completed fithis form will be used by State agencies to prepare Information Ristatement.	orm will prevent del leturns (1099). Se	lays when processing payments. Info e reverse side for more information a	ormation provided in
	NOTE: Governmental entities, federal, State, and local (includin PAYEE'S LEGAL BUSINESS NAME (Type or Print)	g school districts), a	are not required to submit this form.	
2	Hoffman Technologies, Inc. SOLE PROPRIETOR - ENTER NAME AS SHOWN ON SSN (La			
2	SOLE PROPRIETOR - ENTER NAME AS SHOWN ON SSN (Le	ast, First, M.I.)	E-MAIL ADDRESS	
	MAILING ADDRESS	BUSINESS ADD	gary@hoffmantech.	COM
	1800 Vernon Street, Suite 8	Same	NE33	
	CITY, STATE, ZIP CODE	CITY, STATE, ZII	P CODE	
,	Roseville, CA 95678	Same		
A PAYEE ENTITY TYPE		(e.g., dentistry, psycho g., attorney services)	- 3 2 7 8 6 7 1	NOTE: Payment will not be processed without an acompanying taxpayer I.D. number.
	∆ ALL OTHE	RS		namber.
CHECK ONE BOX ONLY	INDIVIDUAL OR SOLE PROPRIETOR ENTER SOCIAL SECURITY NUMBER: (SSN required by a	authority of California F	Revenue and Tax Code Section 18646)	
4	X California resident - Qualified to do business in Cal		•	
PAYEE RESIDENCY STATUS	California nonresident (see reverse side) - Paymen withholding.		-	state income tax
5	I hereby certify under penalty of perjury that the Should my residency status change			and correct.
	AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or P	rint)	TITLE	
	Gary C. Hoffman		CEO/Presid	ent
	SIGNATURE Some	DATE	TELEPHONE 1, 2006 (916-782-	5267
	Rlease return completed form to 1		/	
6	Department/Office:			
LJ	Unit/Section:			<del></del>
	Mailing Address:			_
	City/State/Zip:			
	Telephone: ()	•	)	-
:	E-mail Address:			-
	E-IIIdii Audiess.			- ,

**EXHIBIT 8.7** 

STATE OF CALIFORNIA-DEPARTMENT OF FINANCE

### **PAYEE DATA RECORD**

'Required when receiving payment from the State of California in lieu of IRS W-9)
). 204 (Rev. 6-2003)

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2	PAYEE'S LEGAL BUSINESS NAME (Type or Print)  SLM CONTRACT FURKITURE, INC.  SOLE PROPRIETOR - ENTER NAME AS SHOWN ON SSN (Last, First, M.I.)  E-MAIL ADDRESS  + im @ SLMEF. C	com
	MAILING ADDRESS 7330-G OPPORTUNITY Rd 7330-G OPPORTUNITY RD CITY, STATE, ZIP CODE SANDIEGO CA 92111 SANDIEGO CA 92111	/
3 PAYEE ENTITY TYPE	ENTER FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN): 42-1582582  PARTNERSHIP CORPORATION:  MEDICAL (e.g., dentistry, psychotherapy, chiropractic, etc.)  LEGAL (e.g., attorney services)  EXEMPT (nonprofit)	TE: rment will not processed tout an ompanying payer I.D. nber.
CHECK ONE BOX ONLY	INDIVIDUAL OR SOLE PROPRIETOR ENTER SOCIAL SECURITY NUMBER: (SSN required by authority of California Revenue and Tax Code Section 18646)	
PAYEE RESIDENCY STATUS	California resident - Qualified to do business in California or maintains a permanent place of business in California nonresident (see reverse side) - Payments to nonresidents for services may be subject to State withholding.  No services performed in California. Copy of Franchise Tax Board waiver of State withholding attached.	
5	I hereby certify under penalty of perjury that the information provided on this document is true and should my residency status change, I will promptly notify the State agency below.  AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print)  TIME THE BOLLEY  SIGNATURE  DATE  TELEPHONE	
6	Please return completed form to: 5-2-06 858 277-	9100
	Department/Office:  Unit/Section:  Mailing Address:  City/State/Zlp:	
	Telephone: ()	

**EXHIBIT 8.7** 

STATE OF CALIFORNIA-DEPARTMENT OF FINANCE

### **PAYEE DATA RECORD**

Required when receiving payment from the State of California in lieu of IRS W-9) ID. 204 (Rev. 6-2003)

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	PAYEE'S LEGAL BUSINESS NAME (Type or Print)	
2	OFFICE DEPOT, Inc.	
	SOLE PROPRIETOR - ENTER NAME AS SHOWN ON SSN (Last, First, M.I.)	4
·	MAILING ADDRESS  Pat. welch (a) officed upo 1  Business Address	.com
	6700 AutoMoll Parkway 6700 AutoMall Parkway CITY, STATE, ZIP CODE Fremont CA 94538 Fremont CA 945	2
	CITY, STATE, ZIP CODE  CITY, STATE, ZIP CODE  CITY, STATE, ZIP CODE	20
	Fremont CA 94538 Fremont CA 945	30
3	ENTER FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN): 59-2663954 NO	OTE:
٦		yment will not processed
PAYEE	MEDICAL (e.g., dentistry, psychotherapy, chiropractic, etc.)	hout an companying
ENTITY TYPE	ESTATE OR TRUST	payer I.D. mber.
	ALL OTHERS	mber.
CHECK ONE BOX	INDIVIDUAL OR SOLE PROPRIETOR	4
ONLY	ENTER SOCIAL SECURITY NUMBER:  (SSN required by authority of California Revenue and Tax Code Section 18646)	•
4		California
	California resident - Qualified to do business in California or maintains a permanent place of business in	
PAYEE	California nonresident (see reverse side) - Payments to nonresidents for services may be subject to State withholding.	e income tax
RESIDENCY	<ul> <li>□ No services performed in California.</li> <li>□ Copy of Franchise Tax Board waiver of State withholding attached.</li> </ul>	
STATUS	Copy of Franchise Tax Board waiver of State withholding attached.	
5	I hereby certify under penalty of perjury that the information provided on this document is true and Should my residency status change, I will promptly notify the State agency below.	correct.
	AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print) TITLE	
	PAT WELCH Vice Mes	sidnt
	SIGNATURE DATE TELEPHONE	
	Stell 5-8-06 (510)497:553)	
	Please return completed form to:	
6	Department/Office:	
	Unit/Section:	
	Mailing Address:	
	City/State/Zip:	
	Telephone: () Fax: ()	-
	E-mail Address:	
į .		